

BENEFIT ENROLLMENT DOCUSIGN PROCESS

(Applies to all listed documents)

1. Go to [Human Resources](#) website:
 - a. Select the “Forms & Policies” under “Quick Links (right hand menu).

Welcome to Human Resources

In efforts to mitigate the spread of COVID-19 and in practicing social distancing, Human Resources will remain open to serve the campus community but with limited staff on-site, between 8:00 am to 5:00 pm.

Please find below our contact information:
For a quick response, Submit a Service Request
Email: hrwww@sfstate.edu
Telephone: (415) 338-1872

HR Client Service Center

Submit Service Request

HR Public Knowledge Base

HR Quick Links

- Calendar & Schedules
- Directives & Guidelines
- **Forms & Policies**
- HRMS Log-In
- Self Service
- SF State Password
- Lactation Room
- HR Directory
- Staff Symposium
- SF State IT Resources
- Coronavirus (COVID-19) Manager(s) and Staff FAQ's
- Temporary Telecommuting Agreement - COVID-19
- Temporary Paid Administrative Leave Request

Future Employees

New Employees

Current Employees

Managers and HR Liaisons

Student Employment

Retirement Services

- b. Scroll to “Benefits” section

Benefits

Medical Benefits

Benefits Health Benefits Forms

Form Title/ Description	Document	Instructions
CalPERS Health Benefits Plan Enrollment for Active Employees (HBD-12) Form	DocuSign	PDF
Flexcash Program Enrollment Authorization Form.	DocuSign	PDF
Health/Dependent Care Reimbursement Account Enrollment Form	DocuSign	PDF

Dental Benefits +

Marriage / Domestic Partnership +

Beneficiary Designation +

Vision +

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c. Select any of the below DocuSign forms:

i. Medical Benefits

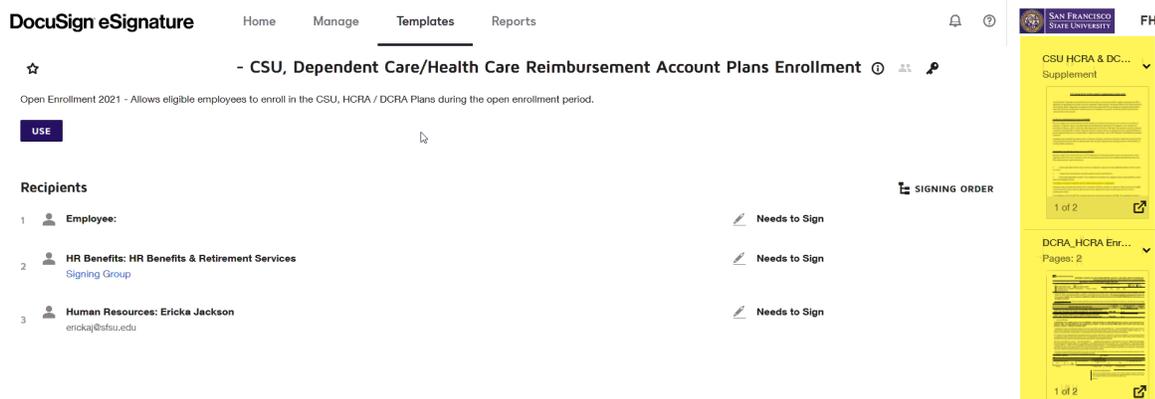
1. CalPERS Health Benefits Plan Enrollment for Active Employees (HBD-12)
2. Flexcash Program Enrollment Authorization To enroll in the Flexcash Program
3. Health/Dependent Care Reimbursement Account Enrollment Form

ii. Dental Benefits

1. CSU Dental Plan Enrollment Authorization (CSU 692)

2. Log into DocuSign with your SF State credentials and Duo Authentication

3. The selected form will open (**Do not select forms on right Highlighted below**). These forms are read only.



4. Select “Use” to open form



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5. Complete your signature routing (**Employee Section Only**) by entering your name:

CaIPERS Health Benefits Plan Enrollment for Active Employees (HBD-12)

Recipients

1 Employee ✍️ NEEDS TO SIGN MORE ▾

Name *

You may select your name or begin typing to auto-populate your name and email

6. Select "Send" (**There is no need to enter any other recipients**)

recipients

1 Employee ✍️ NEEDS TO SIGN MORE ▾

Name *

Email *

2 Supervisor ✍️ NEEDS TO SIGN MORE ▾

Name *

Email *

3 Department Administrator/Dean ✍️ NEEDS TO SIGN MORE ▾

Name *

Email *

4 Fee Waiver Coordinator ✍️ ALLOW TO EDIT MORE ▾

Signing Group Name *

HR Benefits & Retirement Services

SEND ADVANCED EDIT DISCARD

7. Select "Sign Now"

CaIPERS Health Benefits P

Recipients

1 Employee ✍️ NEEDS TO SIGN MORE ▾

Name *

Do you want to sign this document now?

SIGN NOW SIGN LATER

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8. Select "Continue". Document will open. **Enter your SF State ID to open required fields. You will be required to view and accept all guidelines.**

DocuSign Envelope ID: C5AC4DE9-1C75-4DCB-BF20-8DE717313AC8

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P.O. BOX 942715
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FAX (800) 959-6545
www.calpers.ca.gov

Health Benefits Plan Enrollment for Active Employees (HBD-12)

SECTION A: Applicant Information (SF STATE ID)

1. Employee Name: (First) (M.I.) (Last) 2. Hire Date: (mm/dd/yyyy)

3. CalPERS ID or Social Security Number: 4. Date of Birth: (mm/dd/yyyy) 5. Gender: Female Male Nonbinary Unknown

6. Residence Address: (Street) (City) (State) (ZIP) (County)

7. Mailing Address (if different): (Street) (City) (State) (ZIP) (County)

8. Use Work ZIP Code for Health Eligibility: Yes No If yes, enter zip code here: (ZIP) Yes No

9. E-mail Address: 10. Primary Phone: Alternate:

SECTION B: Type of Action

11. Enroll in a Health Plan Add/Delete Dependents Change Health Plan Cancel All Coverage Decline Coverage

SECTION C: Type of Permitting Event

12. New Employee New Contracting Agency Marriage or Domestic Partnership Date (mm/dd/yyyy): Open Enrollment Move Delete Dependent Due to Death Divorce or Domestic Partnership Termination Birth/Adoption Other:

13. Permitting Event Date: (mm/dd/yyyy) 14. Name of Health Plan: (If changing health plans, list new plan name)

SECTION D: Subscriber and Dependent Information (List yourself and all of your dependents to be enrolled on your health plan)

15. Name (First, M.I., Last)	Relationship Code **	Gender	Date of Birth (mm/dd/yyyy)	CalPERS ID or Social Security Number	Action	Primary Care Physician
	SELF				<input type="checkbox"/> Add <input type="checkbox"/> Delete	
					<input type="checkbox"/> Add <input type="checkbox"/> Delete	
					<input type="checkbox"/> Add <input type="checkbox"/> Delete	
					<input type="checkbox"/> Add <input type="checkbox"/> Delete	
					<input type="checkbox"/> Add <input type="checkbox"/> Delete	
					<input type="checkbox"/> Add <input type="checkbox"/> Delete	
					<input type="checkbox"/> Add <input type="checkbox"/> Delete	

9. Complete & Sign (If you do not have an electronic signature on file, you will be prompted to create one).
10. Select "Finish". The document will route to the authorized individuals / departments.
11. Upon completion of all signatures, the employee will receive an email notification and will be able to download for their records.